

Annual Notice of Medicaid Claims Defects

Note that this report is now due annually, not quarterly.
Provide information for full calendar year.

1. Report may be based on Medicaid Claims
OR Medicaid Claims Lines.

Indicate the basis you are using:

choose ☐ Medicaid Claims
only one ☐ Medicaid Claim Lines

Use same basis throughout this filing

2. Report total Medicaid
claims/claim lines
received in report year

3. Report total number of
second denied Medicaid
claims/claim lines in report
year

4. Report second denied
Medicaid claims/claim lines
as a % of total claims
processed in report year

5. Use the formats below to prepare the Report and Summary using your information technology.

Provide report in black print on 8 1/2" x 11" white paper. Use easily readable type, such as Arial 7pt. or larger.

Number pages of each report in this format: Page X (page number) of Y (total pages). Example: Page 1 of 3

Report Claim or Claim Line rejected a SECOND TIME. Do not report Claims/Claim Lines rejected only once!

Label columns in the order shown below. Use a line for each claim or claim line with defect (rejected twice). Use at least 3 spaces or a vertical line to separate columns. Record all dates in MM-DD-YY format.

REPORT FORMAT: Please sort report in ascending order based on Provider Federal Employer ID (FEIN). Number pages as Page X (page number) of Y (total pages of report).

QHP Claim Identifier	Provider name	Provider type code	Provider's Federal Employer ID (FEIN)	Date of Service	Date claim was received	Date claim rejection notice sent to provider	Rejection code (FIRST rejection)	Date SECOND claim was received	Date SECOND claim rejection notice sent to provider	Rejection code (SECOND rejection)
S123456	Sample Clinic	XX	222222222	02-22-22	03-22-22	04-22-22	123456	05-22-22	06-22-22	654321

Each reported claim should look similar to this example

SUMMARY FORMAT: Label columns as shown below to prepare a Summary by Rejection Code. Number pages as Page X (page number) of Y (total pages of summary). Please sort summary by "Second denied Medicaid claims as a percentage of total..." (last column) in descending order (highest percentage first, lowest percentage last)

Rejection Code	Description of rejection code	Number of Medicaid claims denied a second time in report period	Second denied Medicaid claims as a percentage of total second denied claims for report period
MEMNEL	Member not eligible at date of service	29	4.27%

Each line should look similar to this example

Filing is required for:
All HMOs
that provide Medicaid services

2009

DUE
March 1, 2010

Bar Code Required - Place Bar Code Here

6. HMO name

Public Act 187 of 2000 amends the Social Welfare Act (Public Act 280 of 1939) to add requirements for timely payments to providers for covered health care services rendered to persons enrolled in Medicaid who are members of a qualified health plan (QHP). MCL 400.111(2)(i) requires that a qualified health plan notify the health professional or facility and the commissioner of a defect in a claim if it is not payable the second time it has been submitted, regardless of the reason.

7. Certification:

I certify that I have thoroughly examined this report. The information contained in and attached to it is complete and correct to the best of my knowledge and belief.

Signature of HMO's authorized representative _____ Date signed _____

Signer's name and title (please type or print) _____

Contact person name and phone number (include area code) _____

Contact person's EMail address _____

8. When this form is complete, attach report and summary.

Mail or deliver allowing adequate time for filing to arrive at our office on or before the due date.

Mail to:

OFIR - Supervisory Affairs
and Insurance Monitoring
PO Box 30220
Lansing MI 48909-7720

Or deliver to:

OFIR - Supervisory Affairs
and Insurance Monitoring
611 W. Ottawa St.
Lansing MI 48933



Michigan Department of Energy, Labor & Economic Growth

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